

CONFIDENTIAL

NAME: _____ DATE: ____/____/____ PAGE: ____ OF ____

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

INDIVIDUAL PROGRAM PLAN

PARTICIPANT

AGENCY/FACILITY

____/____/____
DATE

I. Evaluations and Assessments Performed: List the Dates Assessments Completed

Medical / Nursing	Initial Medical Evaluation ____/____/____	Dental Evaluation ____/____/____
	Neurological Exam ____/____/____	Nutrition ____/____/____ Motor ____/____/____
	Speech ____/____/____	Nursing ____/____/____ Hearing ____/____/____
	Vision ____/____/____	Language ____/____/____ Other ____/____/____
Psychological	ABS ____/____/____	WAIS ____/____/____ CIIS ____/____/____
	WISC-R ____/____/____	ABAS-II ____/____/____ Other ____/____/____
Habilitative / Social	Social History ____/____/____	Training/Education ____/____/____
	Recreation/Leisure ____/____/____	Habilitation - WVATTS ____/____/____
	Brigance ____/____/____	L.A.P. ____/____/____
	Other ____/____/____	

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II. Evaluation and Assessment Summary: (List Strengths/Needs in all Areas)

<p>a. Medical/Health:</p> <p style="text-align: center;"><u>Strengths</u></p>	<p style="text-align: center;"><u>Needs</u></p>
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b. Psychological:

Strengths

Needs

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c. Social:

Strengths

Needs

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d. Habilitation:

Strengths

Needs

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e. Other:

Strengths

Needs

f. Projected Date of Community Placement: ____/____/____

DD-5

New - July, 1985

Current – May, 2014

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III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

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III. Individual Service Plan (Continued)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

REEVALUATION DATE ____/____/____

_____ PARTICIPANT	_____ DATE	_____ SERVICE COORDINATOR	_____ DATE
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_____ PARENT/LEGAL REPRESENTATIVE	_____ DATE	_____ SERVICE COORDINATOR
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IV. Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

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IV. Individual Habilitation Plan (Continued)

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

RE-EVALUATION DATE _____ 90 DAYS _____ 180 DAYS _____ ANNUAL

_____	____/____/____	_____	____/____/____
PARTICIPANT	DATE	SERVICE COORDINATOR	DATE
_____	____/____/____	_____	____/____/____
PARENT/LEGAL REPRESENTATIVE	DATE	SERVICE COORDINATOR SUPERVISOR	DATE

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V. Signatures:

Participant's Printed Name/Role	Signature	Agency	Agree	Disagree*	Time Spent
Individual					
Parent/Legal Rep.					
Service Coordinator					
Physician/RN					
Psychologist					
Social Worker					
Advocate					
Day Program Supervisor					
QIDP					

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

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VI. RATIONALE FOR DISAGREEMENT WITH IPP:

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